COASTAL TRANSPORT CO., INC.
1603 Ackerman Road
San Antonio, TX 78219

REQUEST FOR MEDICAL/FAMILY LEAVE OF ABSENCE

NAME: _____ **EMP No.:** _____

TERMINAL: _____ **DATE:** _____

In accordance with company policy, I hereby request a Medical/Family Leave of Absence for approximately _____ week(s) for the following reason (check one):

☐ **ILLNESS**

☐ **INJURY** (Off-the-Job)

☐ **FAMILY MEDICAL** Family Member:_____

Explain the reason in detail: _____

_____

_____

_____

Doctor's Name: _____

Doctor's Address: _____

City, State, Zip: _____

Doctor's Telephone Number: _____

Doctor's Excuse OR Written Statement must be attached.

_____ _____
Employee's Signature Date

APPROVAL:

_____ _____
Supervisor's Signature Date

LEAVE OF ABSENCE:

Last Day Worked: _____ Date Returned to Work: _____